Enter text NEXT

4_MA - Masters Level SS311222.pdf

Provider Self-Introduction

This form is designed to write your self-introduction that will be posted on our behavioral health website, www.cignabehavioral.com. This form assists individuals in their search to select a participating behavioral health care professional.

Note: We recommend typing your self introduction using a word processing program on your computer and using the and paste function to add the information to this form.

Items to Include	Items to Avoid
Describe your office setting (e.g., handicapped accessible, private entrance, etc.).	Introduction should be for a specific health care professional, and not a group or clinic.
Share your practice style (e.g., goal-oriented, family therapy-based, etc.).	Resumes or Curriculum Vitae cannot be accepted a provider self introduction.
Include any unique office hours (e.g., weekends or late evenings).	Avoid clinical and professional jargon.
Give individuals an idea of what to expect at their initial visit.	Limit to a 300 word maximum.

Complete your self-introduction here:

Graduate School:

Year of Graduation:

Upload a photo of yourself; which will be posted with your self-introduction:

FOR INTERNAL USE ONLY: MHS #: 0100994-00

1. PROVIDER INFORMATION (* indicates required fields)

A. DEMOGRAPHIC INFORMATION Please Print Legibly

Last Name*	First Name*	Middle Initial	☐Male ☐Female
Mailing Address Line 1*	Mailing Address Line 2*		
City*	County*	State* / Zip*	Telephone #: Fax*: Cell Phone #: (Include area code)
Social Security Number *	Date of Birth *	Professional Designation or Title*	
U.S. Citizen: ☐ Yes ☐ No	Internet E-mail address (used for business correspondence):		
Indicate any other name you may have used in the past* (e.g., maiden name, etc).	CAQH ID #: National Provider Identifier #:		

2. REFERRAL INFORMATION

A. LICENSED DISCIPLINE: Indicate the primary discipline under which you are LICENSED and/or CERTIFIED at the highest level to practice independently.

- ☐ Addictionologist
- ☐ APN w/ Prescriptive Authority (NP or CNS)
- ☐ APN w/o Prescriptive Authority (NP or CNS)
- ☐ Alcohol/Drug/Substance Abuse Counselor
- ☐ Art Therapist
- ☐ Behavioral Analyst
- ☐ Developmental Behavioral Pediatrician
- ☐ Licensed Mental Health Counselor (Highest Level)
- ☐ Doctor of Osteopathy
- ☐ EAP
- ☐ Licensed Clinical Psychologist (Doctorate Level)
- ☐ Licensed Psychologist (Master's Level)
- ☐ Licensed/Certified Psychological Examiner
- ☐ LLP – Limited License Psychologist (Nevada)
- ☐ Licensed Clinical Psychoanalyst
- ☐ Licensed/Certified Social Worker (Highest Level)
- ☐ Social Worker – Board Certified Diplomat
- ☐ Social Worker – Board Certified Children and Family
- ☐ Licensed Marriage and Family Therapist (Highest Level)
- ☐ Licensed Professional Counselor (Highest Level)
- ☐ MD – Non-Psychiatrist
- ☐ Pastoral Counselor
- ☐ Physician Assistant
- ☐ Psychiatrist
- ☐ Child/Adolescent Psychiatrist
- ☐ Geriatric Psychiatrist
- ☐ Qualified Mental Health Practitioner (Nebraska)
- ☐ Other (specify): _____

B. POPULATION TREATED

Identify the percentage of your practice dedicated to the following patient population categories (must total 100%).

Population	% of Practice	Are You Currently Accepting New Patients?	Modality	% of Practice
Child (0-5) (YC)		☐ Yes ☐ No	Inpatient	
Child (6-12) (CI)		☐ Yes ☐ No	Day Treatment	
Adolescent (13–17) (AO)		☐ Yes ☐ No	Outpatient	
Adult (18-64) (AU)		☐ Yes ☐ No	Intensive Outpatient Programs	
Geriatric (65+) (GT)		☐ Yes ☐ No		

C. LANGUAGE

Identify any foreign language(s) or sign language that you use fluently in treating patients (select no more than 5):

- ☐ American Sign Language (SG)
- ☐ Armenian (AN)
- ☐ Arabic (AR)
- ☐ Braille
- ☐ Chinese (CH)
- ☐ Creole/Haitian
- ☐ Dutch (DU)
- ☐ Farsi (FA)
- ☐ French (FR)
- ☐ German (GE)
- ☐ Greek (GR)
- ☐ Hebrew (HE)
- ☐ Hindi (HI)
- ☐ Hungarian (HU)
- ☐ Italian (IT)
- ☐ Japanese (JA)
- ☐ Korean (KO)
- ☐ Mandarin
- ☐ Norwegian (NW)
- ☐ Polish (PL)
- ☐ Portuguese (PO)
- ☐ Other (OT): _____
- ☐ Russian (RU)
- ☐ Spanish (SP)
- ☐ Swedish (SW)
- ☐ Tagalog/Filipino (PH)
- ☐ Vietnamese (VI)
- ☐ Yiddish (YI)

D. ANSWERING SERVICE: Indicate how you can be reached after hours:

Answering Service Name	Phone #:
Pager or Beeper #	Voice Mail #

E. CLINICAL EXPERTISE (SPECIALTIES):

From the list below, rank order **a maximum of six (6) specialty areas** for which you have training and expertise. For example, "1" means primary specialty, "2" means secondary specialty, etc. If you indicate more than six specialties, they will not be documented. These specialties will be used to assist Beacon Health Options in making clinically appropriate referrals. Please remember to select applicable specialties when applying for the specialty networks.

- ☐ Addictions, Non-Chemical (S.ANC)
- ☐ Adoption (S.ADP)
- ☐ Affective Disorders (S.AFF)
- ☐ Alcohol / Chemical Dependency (S.ACD)
- ☐ Anger Management/Impulse Disorders (S.ANG)
- ☐ Anxiety Disorders (S.ANX)
- ☐ Applied Behavioral Analyst
- ☐ Autism Spectrum Disorders (S.ASP)
- ☐ Attention Deficit Hyperactivity Disorder (ADHD)/School-related problems (S.ADD)
- ☐ Childhood Behavioral Disturbances (S.CBD)
- ☐ Chronic Pain (S.CHP)
- ☐ Co-Occurring Disorders (S.COD)
- ☐ Death & Dying/Terminal Illness (S.CHT)
- ☐ Disability Assessment (M.DSA)
- ☐ Disability Treatment (S.DST)
- ☐ Dissociative Identity Disorders (S.MPD)
- ☐ Domestic Violence (S.VIO)
- ☐ Eating Disorders (S.EAT)
- ☐ Fitness for Duty Assessment (M.FDE)
- ☐ Forensics (S.FOR)
- ☐ Gangs/Cults (S.GNG)
- ☐ Gay/Lesbian/Bisexual/Transgender/ Sexual (S.GLS)
- ☐ Geropsychiatry/Alzheimers (S.GAL)
- ☐ Grief/Bereavement (S.GRF)
- ☐ Head Trauma (S.HTR)
- ☐ Hearing Impaired (S.HIM)
- ☐ HIV / AIDS (S.HIV)
- ☐ Marital/Separation/Divorce (S.MAR)
- ☐ Men's Issues (120C) (S.MEN)
- ☐ Mental Retardation/Developmental Disabilities(S.MRI)
- ☐ Military Lifestyle Issues (S.MIL)
- ☐ Neuropsychology (S.NEU)
- ☐ Obsessive Compulsive Disorder (S.OCD)
- ☐ Panic/Phobias (S.PHO)
- ☐ Personality Disorders (S.PER)
- ☐ Physical Abuse Perpetrators (S.PAP)
- ☐ Physical Abuse Victims (S.PAV)
- ☐ Post-Traumatic Stress Disorder (S.PSD)
- ☐ Reactive Attachment Disorder (S.RAP)
- ☐ Schizophrenia (S.SCH)
- ☐ Severe & Persistent Mental Illness(S.SPM)
- ☐ Sex Abuse Perpetrators (S.SAB)
- ☐ Sex Abuse Victims (S.SAB)
- ☐ Sexual Dysfunction (S.DYF)
- ☐ Sleep Disorders (S.SLP)
- ☐ Suboxone Therapy (S.SUB)
- ☐ Trichotillomania (S.TRM)
- ☐ Women's Issues (S.WMN)
- ☐ Telehealth Services (S.THS)
- ☐ Telephonic Counseling (S.TCO)
- ___TMS (S.TMS)

F. THERAPEUTIC MODALITIES:

From the list below, please **rank order a maximum of six (6) modality** areas that you use when treating patients. For example, "1" means primary specialty, "2" means secondary, etc. These modalities will be used to assist Beacon Health Options in making clinically appropriate referrals. Please remember to select applicable modalities when applying for the specialty networks.

☐ Behavior Modification Therapy (M.BEH) ☐ Brief Therapy (M.BRF) ☐ Child Therapy (M.CHI) ☐ Child Therapy (5y and younger) (M.CHY)	☐ DFWP (Drug Free Workplace; Federally Required training & consultations); EAP/ Organizational Development/ Workplace Issues; Stress Management (M.WRK)	☐ Neuropsychological Testing (M.NSY) ☐ Pastoral Counseling (M.CHR) ☐ Play Therapy (M.PLY) ☐ Psych Testing (M.PST)
☐ Cognitive Behavioral Therapy (M.COG)	☐ ECT Inpatient (M.ECT)	☐ Psychopharmacology (M.PSP)
☐ Critical Incident Stress Management	☐ ECT Outpatient (M.ECO)	☐ Solution Focused Therapy (M.SFT)
☐ Dialectical Behavioral Therapy (M.DBT)	☐ Family Therapy (M.FAM)	☐ Worker's Comp Evaluations (M.WCE)
	☐ Group Therapy (M.GRP)	☐ Other_____

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

3094

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Fingerprinting Information

(Please Print Clearly)

Name:_____ Social Security Number: _____

Aliases:_____

Date of Birth: _____ Place of Birth: _____
(MM/DD/YYYY)

Citizenship: _____ Race: _____ (W-White/Latino(a); B-Black; A-Asian; NA-Native American; U-Unknown)

Sex: _____ Weight: _____ Height: _____
(M=Male; F=Female)

Eye Color:_____ Hair Color: _____

Address: _____ Apt. Number: _____

City:_____ State: _____ Zip Code: _____

Hospital Privileges Questionnaire

Do you currently hold staff privileges in a hospital? Yes or No (Please circle)

If no, do you utilize a hospitalist group to admit on your behalf? Yes or No (Please circle)

Hospitalist Group(s): USF Physicians Group

Signature: _____ Date:_____

Print Name: _____